

# **Exhibit 41**

## Kesting, Virginia

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**From:** Kesting, Virginia  
**Sent:** Wednesday, October 15, 2014 1:33 PM  
**To:** Kruakaew, Rattakan  
**Subject:** RE: Subpoena  
**Attachments:** ECFMG and Maryland Board of Physicians E-mail Correspondence.pdf

Hi Rattakan,

Per our conversation, attached please find additional material to be included for the file of John Nosa Akoda 0-553-258-5.

Virginia

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**From:** Kruakaew, Rattakan  
**Sent:** Thursday, October 09, 2014 11:35 AM  
**To:** Fitzpatrick, Eleanor; Kelly, Bill; Dahn, Susan; Kesting, Virginia; Corrado, Kara; Spizuco, Matthew; Griffin, Darrell; Steans, Frances; Donatto, Thai  
**Subject:** Subpoena  
**Importance:** High

Good morning,

We received a subpoena requesting for records of these two applicants:

0-482-700-2 Oluwafemi Charles Igberase  
0-553-258-5 (John Nosa Akoda)

If you have any records related to the two applicants, kindly send me copies by end of tomorrow, Friday 10/10. Please let me know if you have any questions or concerns.

Thanks so much for your prompt assistance.

Rattakan

**(Ms.) Rattakan Kruakaew, M.S.**

Administrative Assistant to William Kelly, MS.  
Associate Vice President for Operations  
Educational Commission for Foreign Medical Graduates (ECFMG)  
3624 Market Street  
Philadelphia, PA 19104  
Tel: 215.823.2103  
Fax: 215.966.7581

## Kesting, Virginia

---

**From:** Dierdra Rufus -DHMH- [dierdra.rufus@maryland.gov]  
**Sent:** Monday, September 29, 2014 3:27 PM  
**To:** Kesting, Virginia  
**Subject:** akoda  
**Attachments:** DOC052.PDF

--  
Dierdra Rufus  
Supervisor, Licensure Unit  
Maryland Board of Physicians  
410-764-5977

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# UNIVERSITY OF BENIN



BENIN CITY, NIGERIA

*Johnbull Enosakhare Akoda*

having satisfied all the requirements of the University  
and passed the prescribed examinations held in

*October 1987*

has been admitted to the degree

of

Bachelor of Medicine: Bachelor of Surgery

Given at Benin City this *6<sup>th</sup>* day of *February* 1988

RECEIVED  
AUG 11 2011  
MARYLAND BOARD OF PHYSICIANS

*[Signature]*  
REGISTRAR

*[Signature]*  
VICE CHANCELLOR



**Kesting, Virginia**

**From:** Kesting, Virginia  
**Sent:** Monday, September 29, 2014 3:57 PM  
**To:** 'dierdra.rufus@maryland.gov'  
**Cc:** Griffin, Darrell  
**Subject:** FW: akoda  
**Attachments:** DOC052.PDF; ECFMG Verification Form (Form 399A) John Nosa Akoda 0-553-258-5.pdf

<b>Tracking:</b>	<b>Recipient</b>	<b>Delivery</b>
	'dierdra.rufus@maryland.gov'	
	Griffin, Darrell	Delivered: 9/29/2014 3:57 PM

Dierdra,

Attached please find a copy of the completed ECFMG Verification Form (Form 399A) sent from the University of Benin, Nigeria, to ECFMG for John Nosa Akoda 0-553-258-5.

The copy of the diploma you forwarded to ECFMG matches the copy of the diploma the University of Benin, Nigeria, certified was authentic.

If you need any additional information, please contact me.

Virginia Kesting, Manager  
 Credentials Services



Educational Commission for Foreign Medical Graduates  
 3624 Market Street | Philadelphia, PA 19104-2685  
 e-mail: [vkesting@ecfm.org](mailto:vkesting@ecfm.org) | Phone: 215.823-2177

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**From:** Dierdra Rufus -DHMH- [<mailto:dierdra.rufus@maryland.gov>]  
**Sent:** Monday, September 29, 2014 3:27 PM  
**To:** Kesting, Virginia  
**Subject:** akoda

--

Dierdra Rufus  
 Supervisor, Licensure Unit  
 Maryland Board of Physicians  
 410-764-5977

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RECEIVED

APR 29 1996

5-690-003

APR 22 1996

Return to: ECFMG  
3624 Market Street  
Philadelphia PA 19104-2685  
USA

Re:

0-553-258-5

DR John Nosa Akoda

I hereby certify that the attached diploma or other credential for the individual noted above is authentic and correct and that I am authorized to certify this on behalf of this institution.

Signature

21st MAY 1996

Date

PROFESSOR L.I. OJGWU, FRCP.  
Name (Printed or Typed)

DEAN FACULTY OF MEDICINE  
Title

UNIVERSITY OF BENIN, BENIN CITY, NIGERIA  
Name of Medical School



I cannot certify that the diploma or other credential for the individual noted above is authentic and correct because:

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Signature

Date

Name (Printed or Typed)

Title

Seal

Name of Medical School

Form 399A--English  
Rev. August 1995



# UNIVERSITY OF BENIN



BENIN CITY, NIGERIA

*Johnbull Enosakhare Akoda*

having satisfied all the requirements of the University  
and passed the prescribed examinations held in

*October 1987*

has been admitted to the degree

of

Bachelor of Medicine: Bachelor of Surgery

Given at Benin City this *6<sup>th</sup>* day of *February* 1988

RECEIVED  
AUG 11 2011  
MARYLAND BOARD OF PHYSICIANS

*[Signature]*  
REGISTRAR

*[Signature]*  
VICE CHANCELLOR



**Kesting, Virginia**

---

**From:** Brooks Whigham -DHMH- [brooks.whigham@maryland.gov]  
**Sent:** Thursday, October 09, 2014 2:52 PM  
**To:** Kesting, Virginia  
**Cc:** Dierdra Rufus -DHMH-  
**Subject:** Charles Akoda, M.D.  
**Attachments:** Application Release - Akoda.PDF

Good afternoon Ms. Kesting,

Ms. Rufus forwarded me your email stating ECFMG cannot release confidential information without a release signed by Dr. Akoda. Please see the attached release Dr. Akoda signed for his Maryland Board of Physicians licensure application authorizing the Board to request any information relating to his license.

If you have any questions, please feel free to ask.

Thank you,

Brooks Whigham  
Compliance Analyst

--  
Brooks Whigham  
Compliance Analyst, Investigations  
Maryland Board of Physicians  
4201 Patterson Avenue  
4th Floor  
Baltimore, Md 21215

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Initial Medical Licensure  
Release and Certification  
10/2009 INT

## RELEASE AND CERTIFICATION

Page  
11 of 11

## 19. Release:

I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

Charles John Nosa Akoda Charles Akoda 7/28/11

Applicant's Name (Printed)

Applicant's Signature

Date

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: N/A

Phone: N/A

Applicant's Signature

Date

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Charles Akoda

Applicant's Signature

7/28/11

Date

22. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to Items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

Charles Akoda

Applicant's Signature

8/3/11

Date

STATE OF Maryland

CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 3rd day of August, 2011, before me, a Notary Public of the State and

City/County aforesaid, personally appeared the Applicant, Charles Akoda, whose likeness is identifiable as that of

the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the

truth in all statements made in this application.

AS WITNESS my hand and notarial seal.

Notary Public

My Commission expires 03-25-2012

SEAL

GEORGE E. OKA  
NOTARY PUBLIC  
PRINCE GEORGE'S COUNTY, MARYLAND  
MY COMMISSION EXPIRES 3-25-2012



STOP! Completed application and check must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297



## Kesting, Virginia

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**From:** Kesting, Virginia  
**Sent:** Wednesday, October 15, 2014 12:05 PM  
**To:** 'Dierdra Rufus -DHMH-'  
**Subject:** RE: Maryland Board  
**Attachments:** John Nosa Akoda United States Medical Licensing Examination® (USMLE) Application and Identification Documents.pdf

Dierdra,

Good afternoon.

This is in response to your e-mail.

Pursuant to receipt by ECFMG of the release Dr. Akoda signed for his Maryland Board of Physicians licensure application authorizing the Board to request any information relating to his license, please see attached copies of identification documents and a copy of one of the United States Medical Licensing Examination® (USMLE) applications John Nosa Akoda 0-553-258-5 submitted to ECFMG.

If you have any questions, please contact me.

Virginia Kesting, Manager  
Credentials Services



Educational Commission for Foreign Medical Graduates  
3624 Market Street | Philadelphia, PA 19104-2685  
e-mail: [vkesting@ecfm.org](mailto:vkesting@ecfm.org) | Phone: 215.823-2177

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**From:** Dierdra Rufus -DHMH- [<mailto:dierdra.rufus@maryland.gov>]  
**Sent:** Thursday, October 09, 2014 11:42 AM  
**To:** Kesting, Virginia  
**Subject:** Maryland Board

Good morning Ms. Kesting, thanks for your previous help with information concerning Dr. Charles Akoda/ Ikwofemi Igberose. I would like to ask for a copy of what the doctor provided to you for identification.( passport, resident card, visa)

Thanks in advance for all of your help.

Charles Ako

--

Dierdra Rufus  
Supervisor, Licensure Unit  
Maryland Board of Physicians  
410-764-5977

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PLEASE DO NOT DETACH

**UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)  
STEP 1 AND/OR STEP 2 EXAMINATIONS**

ADMINISTERED TO STUDENTS/GRADUATES OF FOREIGN MEDICAL SCHOOLS BY  
THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, 3524 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, USA  
PHONE: 215 386-5900 CABLE: EDCOUNCIL.PHA

## PART A

NOTE: All items on all sides of the application must be filled out completely for initial and reexamination or application will not be accepted.  
Use typewriter or block print in ink.

① ECFMG EXAMINATION HISTORY:	Have you ever submitted an application to ECFMG for any examination, even if you did not take the examination? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
② NAME: Print your name as you want it to appear on the Standard ECFMG Certificate and on your official USMLE record	If yes, enter your USMLE Identification Number (ECFMG Applicant Number) in this box: <b>0-553-258-5</b>	
③ ADDRESS: Use address to which admission permit and other notification from ECFMG should be sent	J   I   O   H   N   First Name A   K   O   D   A   Last Name (Surname) M   O   S   A   Full Maiden Name (For married women only)	
④ U.S. SOCIAL SECURITY AND/OR NATIONAL IDENTIFICATION NUMBERS:	Previous Name Please include a copy of the legal document that verifies this name change.	
⑤ STATUS OF MEDICAL SCHOOL STUDENT: Must be completed by students.	5   8   10   10   6   ILLAINTIRIELLI AVENUE Number/Street APT INQ 8 11 10 Apartment Number ALEXANDRIA City VIRGINIA State/Country 22312 Zip or Postal Code	
⑥ REGISTRATION: Select no more than one box for each Step and/or ECFMG English test for which you are applying.	Enter U.S. Social Security Number □ □ □ □ □ □ □ □ Country: _____	
⑦ EXAMINATION FEE(S): Enter the amount enclosed on the line provided	Enter National Identification Number and Country _____ Country: _____	
⑧ HANDEDNESS:	⑨ If you are applying for Step 1, will you have completed two years of medical school by the date of that examination? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If you are applying for Step 2, will you have completed or be within 12 months of completion of the formal didactic curriculum at your medical school by the date of that examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Step 1 (Check one box only) <input type="checkbox"/> June 11-12, 1996 or <input checked="" type="checkbox"/> October 15-16, 1996	
	Step 2 (Check one box only) <input type="checkbox"/> March 5-6, 1996 or <input type="checkbox"/> August 27-28, 1996	
	ECFMG English Test (Check one box only) <input type="checkbox"/> March 6, 1996 or <input type="checkbox"/> August 28, 1996	
	If your center selections are not available, ECFMG reserves the right to assign a center. Step 1: (1) NEW YORK 330 City Center No. (2) NEW YORK 330 City Center No. (3) City Center No. Step 2 and/or ECFMG English Test: (1) City Center No. (2) City Center No. (3) City Center No.	
	Fees must be paid in United States funds. Checks, bank drafts or money orders are to be made payable to the ECFMG. Do not send cash. Step 1 Basic Medical Science Examination \$440 Step 2 Clinical Science Examination \$440 ECFMG English Test \$ 40 Enter amount enclosed \$ PAID/Credit	
	FOR OFFICE USE ONLY	

APPLICATION FORM 104S, February, 1998

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## PART B

⑨ SECONDARY SCHOOL/ COLLEGE UNIVERSITY ATTENDED:	List any secondary school, college, or university attended.		Dates Attended				No. School Years	
			From To					
	Name City/State/Country		MC YR		MO YR			
⑩ MEDICAL DEGREE AND	Title of Medical Degree <u>MBBS.</u>		Date Conferred/Expected: * <u>MO. 10</u> <u>YR. 87</u>				No. of Years Attended	
	* If the degree has been conferred, a photocopy must be sent to ECFMG. See Medical Education Credentials section of the ECFMG Information Booklet.							
⑩① MEDICAL SCHOOL:	Name of Medical School from which you graduated or expect to graduate.		Dates Attended				No. of Years Attended	
	LIST EXACT NAME AND ADDRESS		From To					
Name City/State/Country		MC YR		MO YR				
⑩② OTHER MEDICAL SCHOOLS ATTENDED:	Name		MC YR		MO YR			
	City/State/Country							
	Name							
	City/State/Country							
⑩② CLINICAL CLERKSHIPS:	Clinical Discipline	Hospital/Clinic	Location (exact address)		Supervising Physician	Dates of Clerkship		
	See Part D of this application for entering clinical clerkships.							
⑪ MEDICAL LICENSURE: Present or Future	Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine:							
	MO. <u>01</u> YR. <u>89</u>		Country or state in which you are licensed: * <u>NIGERIA</u>					
⑫ HOSPITAL TRAINING: Residency or fellowship	Hospitals		Position(s)		Dates			
⑬ EMPLOYMENT: Present employment only	Institution/Company		Position		Dates			
	Name:							
	Street:							
	City/State/Country:							
⑭ BIRTHDATE/ BIRTHPLACE:	Day <u>01</u> Month <u>01</u> Year <u>59</u>		Location: <u>BENIN CITY EDO STATE</u>					
⑮ GENDER:	Please check one: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		⑮ NATIVE LANGUAGE: <u>EDO</u>					
⑰ CITIZENSHIP:	(Complete all three)							
	A. AT BIRTH <u>NIGERIAN</u>		USA <input type="checkbox"/> or Other <input type="checkbox"/> (Specify) _____					
	B. UPON ENTERING MEDICAL SCHOOL		USA <input type="checkbox"/> or Other <input type="checkbox"/> (Specify) _____					
	C. NOW <u>NIGERIAN</u>		USA <input type="checkbox"/> or Other <input type="checkbox"/> (Specify) _____					
⑱ OTHER EXAMINATION HISTORY AND APPLICANT NUMBERS:	Check below the organizations to which you may have applied previously; enter the date of the most recent examination that was administered to you and the identification number that was assigned to you by that organization.							
	ORGANIZATION		DATE OF MOST RECENT EXAMINATION TAKEN		APPLICANT IDENTIFICATION NUMBER			
	<input type="checkbox"/> NATIONAL BOARD OF MEDICAL EXAMINERS		MO. <u>1</u> YR. <u>9</u>		NBME Parts I/II <u>          </u>			
			MO. <u>1</u> YR. <u>9</u>		USMLE Steps 1/2 <u>          </u>			
	<input type="checkbox"/> STATE LICENSING AUTHORITY IN THE UNITED STATES		MO. <u>1</u> YR. <u>9</u>		FEDERATION IDENTIFICATION NUMBER (FIN) <u>          </u>			
					FLEX <u>          </u>			

PART C



## PART C

Students and graduates must sign the application in the presence of their Medical School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See B below) and must explain in writing why the application form could not be signed in the presence of a medical school official. (See B.1 below.)

Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature.

All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.

I hereby certify that the information in this application is true and accurate to the best of my knowledge and that the photographs enclosed are recent photographs of me.

I also certify and acknowledge that I have received the current edition (that which pertains to the administration for which I am registering) of the combined Information Booklet on ECFMG Certification and Application for USMLE Step 1 and Step 2 examinations and USMLE Bulletin of Information, am aware of the contents of both sections and meet the eligibility requirements set therein.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action. (See Information Booklet for additional details concerning Validity of Scores and Irregular Behavior.)

I understand that the ECFMG certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

Signature of Applicant  
(In Latin Characters)

x

Johanna Akeda

Date

8/29/96

A. I hereby certify that the photograph, signature, and information entered on Section 13 of this form accurately apply to the individual named above.

Signature of Medical School Official  
(In Latin Characters)

x

J. J. Bousilek

Official Title

Date

Institution

B. I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn to before me by the applicant on this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_.

x

Signature of Consular Official, First Class Magistrate, Notary Public (In Latin Characters)

Official Title

B.1 Explain in the space below why the application could not be signed in the presence of your medical school dean, vice dean or registrar. Any explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

## 19 CERTIFICATION BY APPLICANT

## 19 CERTIFICATION BY MEDICAL SCHOOL OFFICIAL

OR

## CERTIFICATION OF IDENTIFICATION WITH EXPLANATION (Pertains to graduates only)

FOR OFFICE USE ONLY	
FORM	DATE
S.A.	
I.D.	
338	
339	
325	
P. 9/1/96	

20 Have you ever been denied licensure or authority to practice medicine by any medical licensing or registering authority, or has any such license or authority to practice medicine ever been suspended or revoked?

If the answer to this question is "Yes," please explain fully on a separate sheet of paper, giving details such as date, location, charge, and action taken; and provide any supporting documents.

☐ Yes☐ No

21 Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the information; however, the processing of your application will not be affected if you choose to leave item 21 blank.

Select the one which best describes your racial/ethnic background.

1 ☐ American Indian/  
Alaskan Native

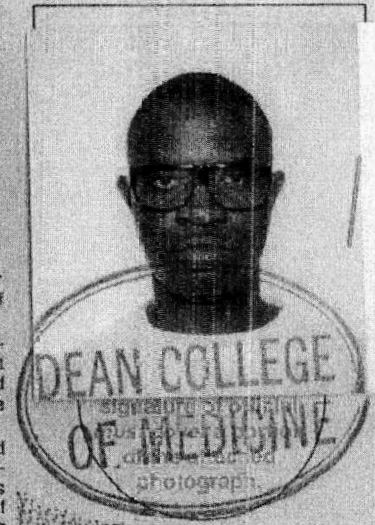
2 ☐ Asian  
Pacific Islander

3 ☐ Hispanic

4 ☒ Black (not of  
Hispanic Origin)

5 ☐ White (not of  
Hispanic Origin)

6 ☐ Other



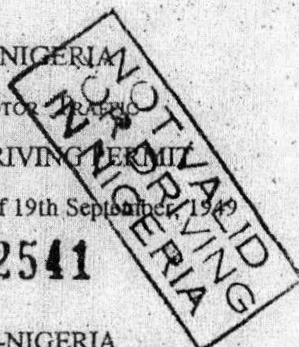


List clerkships (rotations, pre-graduate internships) for each clinical discipline.

ECFMG RUSS 0003969

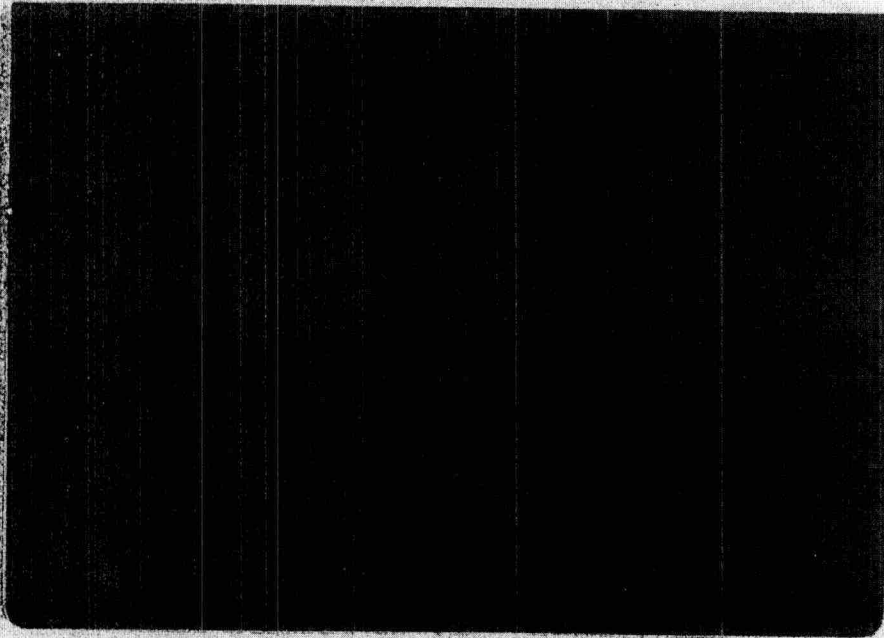


REPUBLIC OF NIGERIA  
INTERNATIONAL MOTOR TRAFFIC  
INTERNATIONAL DRIVING PERMIT  
Convention on Road Traffic of 19th September, 1949  
No 222541  
Issued at LAGOS-NIGERIA  
Date 6 - 12 - 95  
VALID FOR FIVE YEARS  
FEDERAL REPUBLIC OF NIGERIA  
PLA  
LAGOS  
Signature or Seal of the  
Association empowered  
by the Authority  
REPUBLIC OF NIGERIA  
PRINCIPAL  
LICENSING AUTHORITY  
6/12/95



REPUBLIC OF NIGERIA  
PRINCIPAL  
LICENSING AUTHORITY  
6/12/95







### CAUTION

*This passport remains the property of the Government of the Federal Republic of Nigeria and may be withdrawn at any time. It is a valuable document and should not be altered in any way or allowed to pass into the possession of unauthorised person. If lost or destroyed the fact and circumstances should be immediately reported to the Passport Office, Abuja, or the nearest Nigerian Mission or Consulate and to the local police. New passports can be issued in such cases only after exhaustive enquiries.*

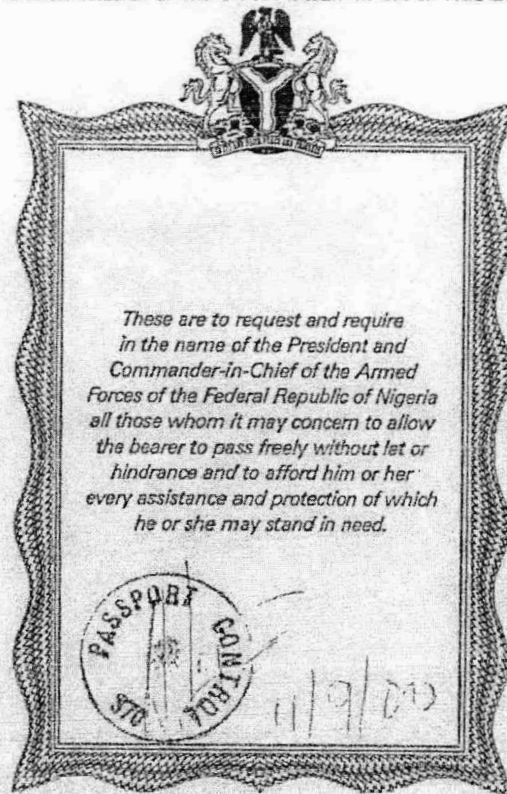


ECFMG\_RUSS\_0003973



<p>This passport is valid for all countries Ce passeport est valable pour tous pays</p>	<p>Renewals / Renouvellements</p>
<p>Previously held Passport No. <u>A294317</u> Issued at <u>313</u> on <u>29/6/89</u> which has been cancelled and a new one issued.  <i>[Signature]</i> Passport Control Officer</p>	
<p>THIS PASSPORT CONTAINS 32 NUMBERED PAGES CE PASSEPORT CONTIENT 32 PAGES NUMÉROTÉES</p>	<p>Observations</p>





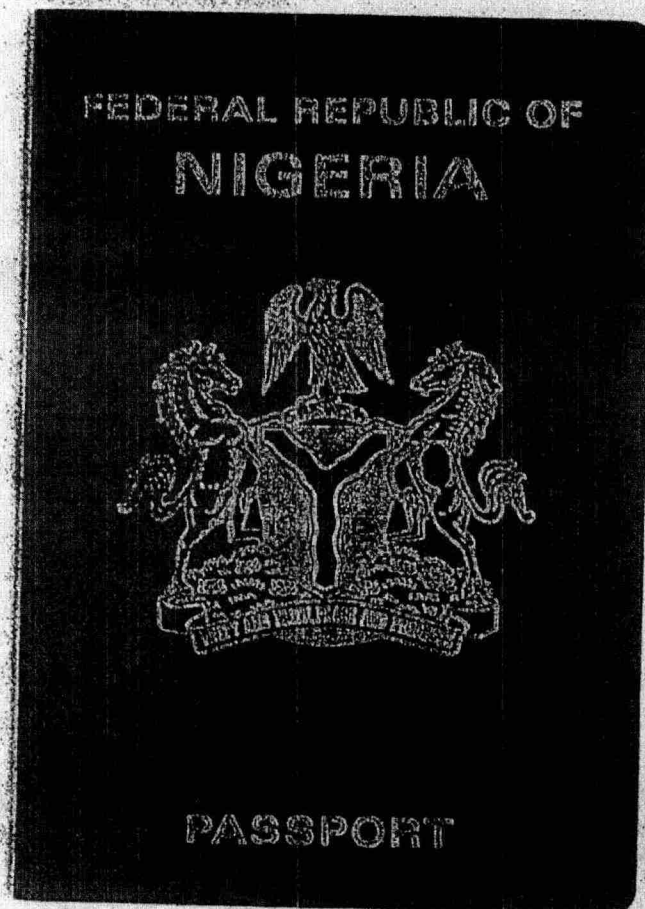
A0662562

FEDERAL REPUBLIC OF  
**NIGERIA**  
RÉPUBLIQUE FÉDÉRALE DU  
NIGÉRIA

PASSPORT  
PASSEPORT

A0662562







Tillnamn 1  
Fornamn 2  
Födelseort 3  
Födelsedag 4  
Hemvist 5

## motorfordon:

Motorfordon och motorfordon på	A
och som, utöver plats för för befordran av gods och kg (7.700 lbs). Till dyllit	B
och vars tillåtna maximivikt ördon får kopplas ett last	C
och som har mer än åtta rfordon får kopplas ett last	D
O, och för vilka foraren är	E

av fordonets vikt, då det är färdigt  
s av vederbörande myndighet i det  
ikt icke överstiger 750 kg (1,650 lbs)

Indragningar  
(land I - VIII)

## Indication relatives au conducteur:

Nom 1  
Prénoms 2  
Lieu de naissance 3  
Date de naissance 4  
Domicile 5

## Catégorie de véhicules pour lesquels le permis est valable:

Motorcycles avec ou sans sidecar, voitures d'infirmités et automobiles à trois roues dont le poids à vide n'excède pas 100 kg (900 livres).	A
Automobiles affectées au transport des personnes et comportant, outre le siège du conducteur, huit places assises au maximum ou affectées au transport des marchandises et ayant un poids maximum autorisé qui n'excède pas 3,500 kg (7,700 livres). Aux automobiles de cette catégorie peut être attelée une remorque légère.	B
Automobiles affectées au transport des marchandises et dont le poids maximum autorisé excède 3,500 kg (7,700 livres). Aux automobiles de cette catégorie peut être attelée une remorque légère.	C
Automobiles affectées au transport des personnes et comportant, outre le siège du conducteur, plus de huit places assises. Aux automobiles de cette catégorie peut être attelée une remorque légère.	D
Automobiles des catégories B, C ou D pour lesquelles le conducteur est habilité, avec remorques autres qu'une remorque légère.	E

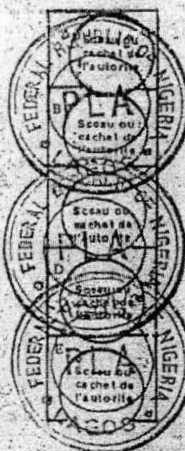
Le terme "poids maximum autorisé" d'un véhicule désigne le poids du véhicule en ordre de marche et de la charge maximum. Le terme "charge maximum" désigne le poids du chargement déclaré admissible par l'autorité compétente du pays d'immatriculation du véhicule. Les remorques légères sont celles dont le poids maximum autorisé ne dépasse pas 80 kg (1,650 livres).

EXCLUSION  
Le titulaire est déchu du droit de conduire sur le territoire (pays) raison de  
Sceau ou  
cachet de  
l'autorité  
Lieu  
Date  
Signature

inscrire l'exclusion dans tout autre espace prévu à cet effet, et l'espace réservé ci-dessus est déjà utilisé.

Exclusions  
(pays I - VIII)

AKODA  
JOHN ROSACHARLES IGBERASE  
LAGOS  
07-1955  
21 CARTER STREET AGBARISO



EXCLUSIONS  
(pays)

I. \_\_\_\_\_ V. \_\_\_\_\_  
II. \_\_\_\_\_ VI. \_\_\_\_\_  
III. \_\_\_\_\_ VII. \_\_\_\_\_  
IV. \_\_\_\_\_ VIII. \_\_\_\_\_

0-553218-1



This permit is valid in the territory of all the Contracting States with the exception of the territory of the Contracting State where issued, for the period of one year from the date of issue, for the driving of vehicles included in the category or categories mentioned on the last page of this permit.

#### LIST OF CONTRACTING STATES

United Kingdom (together with	Israel
Aden State	Italy
Bahamas	Ivory Coast
Barbados	Jamaica
British Honduras	Japan
Fiji	Jordan
Gibraltar	Lebanon
Grenada	Luxembourg
Guernsey	Malagasy Republic of
Hong Kong	Malawi
Isle of Man	Malaysia
Jerry	Mali
Mauritius	Malta
Southern Rhodesia	Mauritania
St. Lucia	Monaco
St. Vincent	Morocco
Seychelles	Netherlands (together with Nether-
Swaziland)	lands Antilles, Netherlands New
Algeria	Guinea and Surinam)
Argentina	New Zealand
Australia (together with Papua	Niger
and the Trust Territory of	Nigeria
New Guinea)	Norway
Austria	Paraguay
Belgium	Peru
Botswana	Philippines
Bulgaria	Poland
Burundi	Portugal (together with all Overseas
Cambodia	Provinces except Macao)
Cameroon	Romania
Canada	Rwanda
Central African Republic	San Marino
Ceylon	Senegal
Chad	Sierra Leone
Chile	Republic of South Africa (together
Congo (Brazzaville)	with South West Africa)
Zaire	Spain (together with African locali-
Cuba	ties and provinces)
Cyprus	Sweden
Czechoslovakia	Syria
Denmark	Tanzania, United Republic of
Dominican Republic	Thailand
Ecuador	Togo
Finland	Trinidad and Tobago
French	Tunisia
Polynesia	Turkey
France (together with all French	Uganda
Overseas Territories and the	U.S.S.R.
Principality of Andorra)	United Arab Republic
Ghana	U.S.A. (together with all territories
Greece	for whose international relations
Guatemala	the U.S.A. is responsible)
Guinea	Upper Volta
Guyana	Venezuela
Haiti	Viet Nam, Republic of
Holy See	Western Samoa
Hungary	Yugoslavia
India	Zambia
Ireland, Republic of	

It is understood that this permit shall in no way affect the obligation of the holder to conform strictly to the laws and regulations relating to residence or to the exercise of a profession which are in force in each country through which he travels.

#### Particular Concerning the Driver

**NOT VALID  
FOR DRIVING  
IN NIGERIA**

**THIS PERMIT MUST  
BE PRODUCED TO THE  
AUTHORITIES OF THE  
COUNTRIES VISITED  
FOR RECOGNITION**

Vehicle for which the permit is valid: s valid:

Motor cycles, with or without a side-car, invalid carriages and three-wheels motor vehicles with an unladen weight not exceeding 400 kg (900 lb).	A
Motor vehicles used for the transport of passengers and comprising, in addition to the driver's seat, at most eight seats, or those used for the transport of goods and having a permissible maximum weight not exceeding 3,500 kg (7,700 lb). Vehicles in this category may be coupled with a light trailer.	B
Motor vehicles used for the transport of goods and of which the permissible maximum weight exceeds 3,500 kg (7,700 lb). Vehicles in this category may be coupled with a light trailer.	C
Motor vehicles used for the transport of passengers and comprising, in addition to the driver's seat, more than eight seats. Vehicles in this category may be coupled with a light trailer.	D
Motor vehicles of categories B, C or D, as authorized above, with other than a light trailer.	

"Permissible maximum weight of a vehicle means the weight of the vehicle and its load when the vehicle is ready for the road.

"Maximum load" means the weight of the load declared permissible by the authority of the country of registration of the vehicle.

"Light trailers" shall be those of a permissible maximum weight not exceeding (1,650 lb).

**EXCLUSION:**  
Holder of this permit is deprived of the right to drive in  
(country)  
by reason of

Seal or  
stamp of  
authority

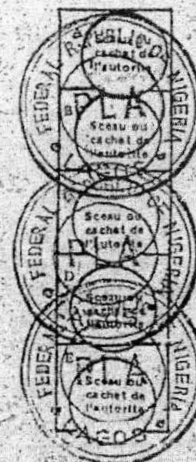
Place \_\_\_\_\_  
Date \_\_\_\_\_  
Signature \_\_\_\_\_

Should the above space be already filled, use any other  
space provided for "Exclusion".

del  
rita  
(ce).

**Exclusions:**  
(countries  
I-VIII)

AKODA  
JOHN ROSACHARE  
LASOS  
21 CARTER STREET



**EXCLUSIONS**  
(pays)

I. \_\_\_\_\_ V. \_\_\_\_\_  
II. \_\_\_\_\_ VI. \_\_\_\_\_  
III. \_\_\_\_\_ VII. \_\_\_\_\_  
IV. \_\_\_\_\_ VIII. \_\_\_\_\_